OFS 4APP
Rev. 03/12
12/10 Issue Usable
II

Louisiana Department of Children and Family Services

OFFICE USE ONLY

Date Received _____

Assigned to _____

Application for Assistance

Is an **EBT** card needed? ☐ Yes ☐ No

Check only those programs for which you are applying:

- ☐ Child Care Assistance Program (CCAP)
- ☐ Family Independence Temporary Assistance Program (FITAP)
- ☐ Kinship Care Subsidy Program (KCSP)
- ☐ Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program)

You can begin to apply and establish your application date by filling in your name, address and signature below and give this form to us today. It will help us to process your application faster if you also give us a telephone number where you can be reached during the day and **provide a copy of a photo ID or other proof of identity.**

Can you read and understand English? (¿Puede leer usted y poder comprender ingles?) ☐ Yes (Sí) ☐ No

If No, what language can you read and understand? (¿Si no, qué idioma le puede lee y comprende?) _____

(Last Name)	(First Name)	(Middle Name)	Social Security Number	
Street or Rural Route	Apt. or Lot#	City and State	Zip Code	Phone#

Mailing Address if different from above: _____

_____
Your Signature

What if you need SNAP benefits right away?

We may be able to get SNAP benefits to you within 4 days of the date you apply if you qualify. You may qualify if:

- The total amount of money you have received or expect to receive this month is less than $150 and you have $100 or less in liquid resources such as cash, savings or checking accounts; or
- Your household's rent/mortgage and utilities are more than your total income and resources; or
- Your household includes migrant or seasonal farm workers.

If any of the above describes your household, answer the following questions:

1. What is the total amount of money that your household will receive this month? Include money from all sources such as earned income, contributions, Social Security, SSI, VA, etc. $ _____
2. How much money does your household have in liquid resources? Include cash on hand, checking accounts, savings accounts, etc. $ _____
3. How much is your household's monthly rent or mortgage? $ _____
4. Do you pay for utilities, such as electricity, gas, water, etc.? ☐ Yes ☐ No
5. Do you pay utility costs for heating or air conditioning? ☐ Yes ☐ No
6. Do you pay telephone expenses? ☐ Yes ☐ No
7. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

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1.	Income		$ _____	Is #1 less than $150? ☐ Yes ☐ No
		+		AND
2.	Resources		$ _____	Is #2 less than $101? ☐ Yes ☐ No
		=		
	Total		$ _____ (A)	If yes to both, Expedite. If no, consider shelter costs.
3.	Rent/Mortgage		$ _____	Is B greater than A? ☐ Yes ☐ No
		+		If yes, Expedite. If no, consider migrant or seasonal farm worker status.
	Utility Standard*		$ _____	Is anyone in the household a migrant or seasonal farm worker? ☐ Yes ☐ No
		=		AND
	Total		$ _____ (B)	Is #2 less than $101? ☐ Yes ☐ No
				If yes to both, Expedite. If no, the case is not expedited.

*If, on the reverse side, the answer to:
#4 is Yes **and** #5 is No, use BUA.
#5 is Yes, use SUA
#6 is Yes **and** #4 **and** #5 are No, use TEL.

Expedited: ☐ Yes ☐ No If yes, enter "Expedited Date" on CP CA screen of LAMI.

Due Date*****: _____

*The case must be certified and the client must have their EBT card in sufficient time to be able to use their SNAP benefits by the 4th calendar day after the date of application. If the 4th calendar day falls on a weekend or holiday, the due date becomes the previous workday.

Expedited status determined by: _____ _____
Signature of Agency Representative Date

A. Tell Us About You

You can choose not to give Ethnicity and Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.

Do you need a new Louisiana Purchase Card? ☐ Yes ☐ No

First Name | Middle Initial | Last Name | Maiden or Other Name

Mailing Address | Apt/Lot No. | City | State | Zip Code

Home Address (If different from mailing) | Apt/Lot No. | City | State | Zip Code

( ) Home Telephone Number | ( ) Cell Telephone Number | ( ) Work or Other Telephone Number

Social Security Number | Parish of Residence

Date of Birth | E-mail Address

Sex: ☐ Male ☐ Female

Ethnicity: Hispanic/Latino? ☐ Yes ☐ No

Highest grade level completed in school? _____

Marital Status:
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Never Married
- ☐ Widowed

Racial Heritage (check all that apply):
- ☐ Asian
- ☐ White
- ☐ Native Hawaiian/ Pacific Islander
- ☐ American Indian/ Alaskan Native
- ☐ Black or African American

Student? ☐ Yes ☐ No

U.S. Citizen? ☐ Yes ☐ No

If no, do you have immigration papers? ☐ Yes ☐ No

Date of entry in U.S.: _____

If you are not registered to vote where you live now, would you like to apply to register to vote? ☐ Yes ☐ No
If you do not check either box, we will assume that you do not want to register to vote at this time.
Do you need help from DCFS with applying for voter registration? ☐ Yes ☐ No

B. Tell Us If You Have An Authorized Representative

An Authorized Representative is someone you allow us to talk with about your SNAP/Child Care Assistance Program benefits. You can name someone, but it is not required.

Would you like to have an Authorized Representative? ☐ Yes ☐ No

If yes, tell us about your Authorized Representative.

Name of Authorized Representative | Relationship to Applicant | ( ) Telephone Number

Address | City | State | Zip Code

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Rights and Responsibilities discussed with applicant? ☐ Yes ☐ No
Reporting requirements explained to applicant? ☐ Yes ☐ No
Is an EBT card needed? ☐ Yes ☐ No
Is there an authorized representative? ☐ Yes ☐ No
Identity verified by: ☐ Driver's License ☐ Identification card ☐ Other
Residency verified by:
Marital status verified by:
Reason for application:
FITAP/KCSP explained? ☐ Yes ☐ No Client selected: ☐ FITAP ☐ KCSP

C. Tell Us About The Other People In Your Household – Do Not Include Yourself

List everyone else who lives in your household, even if you are not applying for them*. You can choose not to give Ethnicity & Racial information. It will not affect your eligibility. This information helps us follow Title VI of the Civil Rights Act of 1964.*

Don't miss out on No Cost Health Insurance for your children! If you check the box below, we will share what you put on this form with the Louisiana Department of Health and Hospitals (DHH). DHH will sign up children who qualify and send you a letter with more information about the Medicaid Program.

☐ **Yes, please share my information with DHH so I do not need to complete another application.**

I understand that if my children get Medicaid, and their medical bills are paid by a private health insurance or lawsuit settlement, Medicaid can get its money back from this source.

Household Members (Enter Name)	Relation to you (NR=Not Related)	Birth Date	Social Security Number	Sex (M/F)	US Citizen? (Yes/No)	ED Level *	Marital Status	Race/ Ethnic Code **
Last First MI	Complete these sections only for those who need benefits							

****Race**: (You may select more than one race)	****Ethnicity:**
AN = Alaskan Native **WH** = White **BL** = Black or African American	**Y** = Hispanic or Latino
AI = American Indian **AS** = Asian **PI** = Native Hawaiian or other Pacific Islander	**N** = Not Hispanic or Latino

***ED Level:** List highest grade completed or GED/college

If you need more space for additional household members, you can write the information on plain paper or ask for an "Additional Household Members Form."
If anyone for whom you are applying is not a U. S. citizen, your worker will complete an Alien Addendum and Checklist with you during your interview.

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Household composition: _____ person household

Are all members linked on LAMI? ☐ Yes ☐ No

Enumeration verified by:

Age and relationship verified by:

Document CR 5

Citizenship: Are all household members U.S. citizens? ☐ Yes ☐ No

If no, complete Alien Addendum and Alien Checklist.

D. Tell Us About Your Household

Please answer the following questions for yourself and everyone else in your home.

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1. Are you or anyone in your household a fleeing felon? ☐ Yes ☐ No

2. Are you or anyone in your household in violation of their probation or parole? ☐ Yes ☐ No

3. Have you or anyone in your household been convicted of a drug-related felony? ☐ Yes ☐ No

   3. If yes, complete supplement.

4. Have you or anyone in your household been disqualified or had their benefits reduced or stopped for breaking the rules of SNAP, FITAP, KCSP, or SSI? ☐ Yes ☐ No

   4. If yes, complete supplement.

5. Do you or anyone in your household need to get away from an abusive situation? ☐ Yes ☐ No

   5. If yes and FITAP/KCSP: Issue Flyer DV

6. Do you or anyone in your household have a disability? ☐ Yes ☐ No

   6. If yes, complete supplement. If FITAP, complete OFS 90 or OFS 90L.

7. Are immunizations current on all children? ☐ Yes ☐ No

   If no, who? _____ Why? _____

   7. Verification: ☐ OFS IM ☐ CR 9 ☐ LINKS

8. Does anyone in your household attend high school, college, vocational or technical school? ☐ Yes ☐ No

   8. If yes, is anyone attending an institution of higher education? ☐ Yes ☐ No
   If yes, complete supplement.

   If **yes**, complete the following for each student:

   a. _____ (Name of Student) _____ (Name of School and Program of study)

   ☐ Eligible student ☐ Ineligible student

   How many hours does the student attend school each week? _____

   Is this considered full or part-time? ☐ Full-time ☐ Part-time

   b. _____ (Name of Student) _____ (Name of School and Program of study)

   ☐ Eligible student ☐ Ineligible student

   How many hours does the student attend school each week? _____

   Is this considered full or part-time? ☐ Full-time ☐ Part-time

9. Are you or anyone in your household pregnant? ☐ Yes ☐ No
   If **yes**, who? _____ Due date: _____

10. Do you usually buy food and prepare your meals with everyone who lives with you? ☐ Yes ☐ No
    If no, who buys and prepares their food separately? _____

11. Have you or anyone in your household received cash assistance or SNAP benefits in Louisiana or from another state? ☐ Yes ☐ No
    a. **If yes**, who? _____
    b. When? _____
    c. What state(s)? _____

12. Do you or anyone in your household have an application pending for any benefits that you are not receiving yet? ☐ Yes ☐ No

    12. If yes, what type?

E. Tell Us About Your Household's Work

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Tell us about any money received by you or anyone in your household for work including full-time, part-time, temporary, or seasonal jobs, self-employment, training, military reserve pay, or work study. This includes money received from wages, salaries, tips, or commissions.

1. Do you or anyone in your household work? ☐ Yes ☐ No

*Complete the following information for **each person** who works for an employer. If anyone works for more than one employer, complete a separate block for each employer. Use plain paper if you need more space.*

2. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Are reimbursements received? ☐ Yes ☐ No

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Use OFS 3

Verified by:

Is commission earned? ☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework? ☐ Yes ☐ No
Rate per piece?

3. Person Who Works For An Employer

Name _____ Start Date _____

Employer's Name _____ Phone # _____

Address _____

How often paid? ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly ☐ Other _____

Are reimbursements received? ☐ Yes ☐ No

# of hours worked per week _____ Hourly wage _____

# of days worked per week _____

Do you ever work overtime? ☐ Yes ☐ No

If yes, how often? _____ How many hours? _____

Are tips earned? ☐ Yes ☐ No

If yes, how much? _____ How often? _____

Is this Work Study? ☐ Yes ☐ No

Use OFS 3

Verified by:

Is commission earned? ☐ Yes ☐ No
If yes, how much?
How often?

Is this piecework? ☐ Yes ☐ No
Rate per piece?

4. Is anyone on strike? ☐ Yes ☐ No

5. Has anyone in your household (including you) stopped working in the last 90 days? ☐ Yes ☐ No

5. If yes, complete supplement.

*Complete the following information for **each person** who is self-employed. This includes fishermen, child care providers, hair dressers, and people who do odd jobs such as cutting grass, picking up cans, etc. Use plain paper if you need more space.*

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6. Persons Who Are Self-Employed

Name	Name
Type of Business	Type of Business
Monthly Business Income	Monthly Business Income
Monthly Business Expenses	Monthly Business Expenses
# Hours Worked Per Week	# Hours Worked Per Week

6. Verified by:

- ☐ Prior year's income tax return
- ☐ Accountant or bookkeeper records
- ☐ Personal business records

7. Is anyone in your household (including you) looking for work? ☐ Yes ☐ No

8. Is anyone in your household a migrant or seasonal farm worker? ☐ Yes ☐ No

9. Do you or anyone in your household rent a room? ☐ Yes ☐ No

10. Do you or anyone in your household pay someone for meals? ☐ Yes ☐ No

7. If yes, complete supplement.

F. Tell Us About Other Income

1. Do you or anyone in your household receive money from a source other than work? ☐ Yes ☐ No **If yes**, check each type of income.

- ☐ Annuity Income
- ☐ Child Support Income
- ☐ Contributions From Family/Friends
- ☐ Disability Insurance Benefits
- ☐ Energy Check
- ☐ Interest Income
- ☐ Loans
- ☐ Military Allotment
- ☐ Oil Lease/Royalties
- ☐ Railroad Benefits
- ☐ Rental Income
- ☐ Retirement Pension
- ☐ Roomer/Boarder
- ☐ Social Security
- ☐ Scholarships/Grants/School Loans
- ☐ SSI
- ☐ Spousal Support/Alimony
- ☐ Tribal Money
- ☐ Training Allowance (WIA)
- ☐ Trust Income
- ☐ Unemployment Benefits
- ☐ Veterans Benefits
- ☐ Workers Compensation
- ☐ Other

For Office Use Only		FITAP		SNAP	
Name	**Age**	**WR Code**	**Reason For Exemption**	**WR Code**	**Reason For Exemption**

2. *For each box checked in #1 of this section on page 5, complete the following information. Include any money you expect to receive in the next 30 days.*

Name	Type Of Income	Amount	How Often (Weekly, Monthly, etc)	Do You Expect This Income To End
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?
				☐ Yes ☐ No **If yes,** when?

3. Is someone court-ordered to pay child support to you or anyone in your household? ☐ Yes ☐ No

4. Do you or anyone in your household receive any money from a child's parent who is not court-ordered to pay? ☐ Yes ☐ No

G. Tell Us About Your Expenses

In order to receive the most benefits possible, you need to tell us about your household expenses. Failure to report any of the expenses listed below will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

HOUSING EXPENSES

1. Check each type of housing expense that you or anyone in your household has.

- ☐ Rent
- ☐ Mortgage(s), (if buying)
- ☐ Lot Rent
- ☐ Homeowner's Insurance
- ☐ Flood Insurance
- ☐ Property Tax
- ☐ Condominium Fees
- ☐ Electricity
- ☐ Gas
- ☐ Sewer
- ☐ Water
- ☐ Garbage
- ☐ Telephone
- ☐ Other

2. *For each box checked in #1 of this section, complete the following information.*

Type Of Housing Expense	Name and Phone Number of Person or Company Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

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Verified by:

3. If yes, complete supplement.

4. If yes, complete supplement.

Living Arrangement

- ☐ Public housing
- ☐ HUD or Section 8 subsidy
- ☐ Other subsidy
- ☐ No rent subsidy

Are insurance and property taxes included in the mortgage payment? ☐ Yes ☐ No

Are any of these bills past due?

☐ Yes ☐ No

Indicate how each expense was verified.

Eligible for:
- ☐ SUA
- ☐ BUA
- ☐ TEL
- ☐ None

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3.	Do you pay housing expenses for a home you are no longer living in but plan to return to? ☐ Yes ☐ No	
4.	Do you pay utility costs for heating and/or air conditioning? ☐ Yes ☐ No	
5.	Does anyone help you pay your housing expenses? ☐ Yes ☐ No	5. If yes, complete supplement.
6.	Do you receive energy assistance? ☐ Yes ☐ No	
	If yes, is the assistance through the Low-Income Home Energy Assistance Program (LIHEAP)? ☐ Yes ☐ No	

DEPENDENT CARE EXPENSES

1.	Do you or anyone in your household pay someone to care for a child, or an adult who is elderly or disabled, so that you or a household member can work, attend training or school, or look for work? ☐ Yes ☐ No	Certified for CCAP? ☐ Yes ☐ No
2.	**If yes**, complete the following information.	

Paid For Whom	Name And Telephone Number Of Person Paid	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

What is co-payment amount?

When management is questionable, use form OFS 4MW.

3.	Does anyone help you pay your dependent care expenses? ☐ Yes ☐ No	3. If yes, complete supplement.

CHILD SUPPORT EXPENSES

1.	Does anyone in your household pay court-ordered child support? ☐ Yes ☐ No	Court-ordered child support expenses:
	If yes, complete the following information.	

Who Pays	Paid to Whom	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

MEDICAL EXPENSES

We can allow a medical deduction in your SNAP case for each household member who has a disability or is over the age of 59. A deduction may be given for medical expenses that are ***more than $35.00 per month.***

1.	Is there anyone in your household who has a disability or is over the age of 59? ☐ Yes ☐ No **If yes**, answer the questions in this section. **If no**, skip to the Household Resources section on the next page.	
2.	Does this person have to pay medical expenses? ☐ Yes ☐ No	
	a. **If yes**, do you want to verify these expenses so that you can receive a medical deduction? ☐ Yes ☐ No	Medical expenses: Use form SNAP 1MW
	b. Check each medical expense that this person has.	

- ☐ Dental Bills
- ☐ Hospital Bills
- ☐ Health Insurance Or Medicare Premiums
- ☐ Medical Appliances
- ☐ Prescribed Medicine
- ☐ Prescription Drug Plan Premium
- ☐ Nursing Home
- ☐ Other

3. *For each box checked in # 2 on page 6, complete the following information.*

Names	Type of Expense	Amount Paid	How Often Paid (Weekly, Monthly, Etc.)

Medical Transportation Expense is money spent for trips to the doctor, hospital, drug store, etc. This includes miles driven in your own vehicle.

4. Does any elderly or disabled person listed on previous page have medical transportation costs? ☐ Yes ☐ No

   a. Does this person use their own vehicle or a household member's vehicle? ☐ Yes ☐ No

   b. **If yes**, complete the following information.

Name Of Person	List All Places Visited For Medical Purposes (Ex. Doctors, Drug Store, Hospital, Etc.)	# Of Miles Traveled Round Trip	Number Of Visits Per Month

   c. Does this person pay someone other than a household member for medical transportation? ☐ Yes ☐ No

   d. **If yes**, complete the following information.

Name Of Person	Who Is Paid	Where Does This Person Go	How Much Does This Person Pay Per Trip	How Many Trips Does This Person Pay For Each Month

If you need more space, you can write the information on plain paper.

5. Will you or anyone in your household be reimbursed for any of the medical expenses listed above? ☐ Yes ☐ No

6. Does anyone help pay the medical expenses? ☐ Yes ☐ No

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5. If yes, complete supplement.

6. If yes, complete supplement.

H. Tell Us About Your Household's Resources

Resources include cash, money in the bank, Certificates of Deposit, stocks, and bonds. Resources do not include personal property such as jewelry, furniture, electrical equipment, or clothing.

1. Check each resource listed below that you or anyone in your household has.

- ☐ Bank/Credit Union Account (Checking)
- ☐ Bank/Credit Union Account (Saving)
- ☐ Joint Account
- ☐ Bonds
- ☐ Cash On Hand
- ☐ Certificate Of Deposit (CD)
- ☐ Money Market Account
- ☐ Mutual Funds
- ☐ Safe Deposit Box
- ☐ Savings Bond
- ☐ Stocks

2. *For each box checked above, complete the following information.*

In Whose Name Is The Resource Listed	Type Of Resource	How Much Is It Worth	Where Is The Resource (Include Name Of Bank Or Company, Where Money Is Held, Address Of Property, Etc.)

3. Have you or anyone in your household received a Federal tax refund in the last twelve months? ☐ Yes ☐ No

4. Have you or anyone in your household received or do you or anyone in your household expect to receive a lump sum of money? ☐ Yes ☐ No

5. Does your name or the name of anyone in your household appear on a bank/credit union account with someone else? ☐ Yes ☐ No
   a. **If yes**, whose names are on the account? _____
   b. Why is this name on the account? _____
   c. Does someone else make deposits into this account? ☐ Yes ☐ No
   d. **If yes**, who and how much per month? _____

6. Have you or anyone in your household sold, traded, given away, or transferred a resource in the last three months? ☐ Yes ☐ No

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Are liquid resources $1500 or less? ☐ Yes ☐ No

3. If yes, complete supplement.

4. If yes, complete supplement.
☐ Countable lump sum
☐ Non-countable lump sum
How was this verified?
☐ Client statement
☐ Bank statement
☐ Other

6. If yes, complete supplement.

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IF YOU ARE APPLYING FOR SNAP BENEFITS ONLY, SKIP TO PAGE 13.

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR CHILD CARE ASSISTANCE

I. Child Care Assistance Program

1. Are you applying for the Child Care Assistance Program? ☐ Yes ☐ No

   If yes, complete this page. **If no**, skip to page 11.

2. List all children who need care and the times each day that the care is needed. If school-aged children need care before and after school, list both times (for example: 7:00 a.m. to 8:00 a.m. and 3:30 p.m. to 6:00 p.m.).

Name Of Child	Age	Type Of Care	Provider's Name Address/Phone Number	Provider's Relationship To Child	Cost Of Care	Time Care Needed Each Day
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				
		☐Child's Home ☐Provider's Home ☐Class A Center ☐Other				

3. List all children who attend or will attend Head Start, Pre-Kindergarten, Kindergarten, or school this school year. _____

4. Do any of the children listed above need specialized care because of a physical, mental, or emotional condition? ☐ Yes ☐ No

   a. **If yes**, who? _____

   b. For what condition? _____

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Did the provider change? ☐ Yes ☐ No

How were special needs verified?

COMPLETE THIS PAGE ONLY IF YOU ARE APPLYING FOR FITAP OR KCSP

J. FITAP or KCSP

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1. Are you applying for FITAP or KCSP? ☐ Yes ☐ No
   If yes, complete this page. **If no**, skip to page 13.

HEALTH INSURANCE

2. Can you or anyone in your household get health insurance through an employer? ☐ Yes ☐ No

2. If yes, provide BHSF Flyer LaHIPP

COLLATERALS

3. Please complete the following information for two people who are not related to you who can verify your household situation.

Name	Address	Daytime Phone Number

CUSTODY

4. If you are not the parent of the child(ren) for whom you are applying, do you have custody? ☐ Yes ☐ No
   a. **If yes**, complete the following information.

4. Custody verified by:

Children For Whom You Have Custody	Type Of Custody	Effective Date Of Custody

A non-custodial parent is a parent who does not live in the home with his/her child. Tell us about the non-custodial parent(s) of each child living in your home. This includes both mother and father if you are not the parent of the child(ren). If a child's biological father and legal father are not the same person, give the requested information for both fathers. Use plain paper if you need more space.

5. **Non-Custodial Parent Information**

Name | Social Security Number | Date of Birth

Street Address

City | State | Phone Number

Employer

Name(s) of Children

Parental Relationship (relationship of children's parents): ☐ Married ☐ Widowed ☐ Never Married ☐ Divorced

6. **Non-Custodial Parent Information**

Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents):	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

7. **Non-Custodial Parent Information**

Name	Social Security Number	Date of Birth
Street Address		
City	State	Phone Number
Employer		
Name(s) of Children		
Parental Relationship (relationship of children's parents):	☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

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Living in the home with qualified relative? ☐ Yes ☐ No

Verified by:

- ☐ Landlord statement
- ☐ School records
- ☐ Collateral
- ☐ Other

NCP: Complete form 4NCP and 4NCP Supplement, if applicable:

Voter Registration

Any citizen in the State of Louisiana who has met the voter registration requirements and applies for public assistance must be provided the opportunity to register to vote.

Please note that the information you give to the agency will remain confidential and will be used only for voter registration purposes. Applying to register or refusing to register to vote will not affect the amount of assistance or services that you may receive from the Department of Children and Family Services.

If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. Contact your worker if you need help. You may file a complaint if you believe that someone has interfered with your:

- right to register to vote,
- right to decline to register to vote,
- right to privacy in deciding whether to register to vote,
- privacy in applying to register to vote, or
- right to choose your own political party or other political preference.

You may file a complaint with: Louisiana Secretary of State, P.O. Box 94125, Baton Rouge, LA 70804-9125. 1-800-825-3805

Read Carefully And Sign Below

I certify under penalty of perjury that the information I have given on this application is true, complete, and correct to the best of my knowledge, including the information I have given regarding the U.S. citizenship or immigration status of all household members. I understand that I and any adult household member will be subject to disqualification and prosecution and will be required to repay ineligible benefits if we knowingly give false, incorrect, or incomplete information in order to obtain or try to obtain financial, food, or child care assistance. By signing this application, I give permission for the release of information to the Department of Children and Family Services by any persons or agencies who have knowledge of my circumstances.

Remember, you must turn in proof of the information you reported on this application form and verification of your identity.

Your Signature (or mark) _____ Date Signed _____

Signature (or mark) of your wife or husband _____ Date Signed _____

Signature of Minor Unmarried Parent _____ Date Signed _____

If you, or your wife or husband, sign with an "X" mark, ask two people to witness the mark; if applicant is blind, ask three people to witness.

Witness _____ Witness _____ Witness _____

Signature of Person Who Helped You Complete this Form and His or Her Relationship to You

Signature _____ Relationship _____

Signature of Agency Representative _____ Date _____

I want to withdraw my _____ application because _____

_____

Signature of Applicant _____ Date _____